AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

September 13, 2021

The Honorable Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

RE: Docket Number CMS-2021-0119; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements; Centers for Medicare & Medicaid Services Proposed Rule and Requests for Comment

Dear Administrator Brooks-LaSure,

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment on the Center for Medicare and Medicaid Services (CMS) CY 2022 Payment Policies Under the Physician Fee Schedule (PFS) Payment proposed rule. Our organization is the policy voice of five Seventh-day Adventist affiliated health systems that include 94 hospitals and more than 600 other health care facilities across the nation.

AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to urban areas of California. With such diverse facilities, populations served and geographic locations, we strive to provide objective and sound policy recommendations that work well for health care as a whole. Our comments below focus on the following issue areas within the proposed rule:

- Telehealth Services
- Appropriate Use Criteria (AUC)
- Quality Payment Program
- Promoting Interoperability
- Medicare Shared Savings Program
- Health Equity

- Indirect Compensation Arrangements

Telehealth Services

AHPA is pleased by the agency's efforts to expand access to telehealth services. The Public Health Emergency (PHE) has demonstrated the value of those services to Medicare beneficiaries, particularly those with chronic diseases or mobility limitations. Through telehealth and telecommunications technology, providers have been able to connect with patients across the nation and deliver timely health care services from the convenience of a patient's home. We encourage the agency to build upon this progress as it is instrumental in modernizing Medicare and improving patient care.

Specifically, AHPA recommends that CMS make the following COVID-19 regulatory flexibilities permanent:

- **Expanded Codes for Telephone Consults** - Allow the provision of Evaluation and Management (E/M) services via audio-only phones, as many Medicare beneficiaries may not have the technology or feel comfortable with the use of video.
- **Frequency of Services** - Remove frequency limitations on subsequent care services provided in nursing facility settings, as beneficiaries receiving nursing care tend to be more vulnerable to viral infection.
- **Remote Patient Monitoring** - Allow clinicians to provide remote patient monitoring services for acute conditions, whether for COVID-19 or for another condition, as this allows for better care management and helps prevent hospital readmissions.
- **Qualifying Providers** - Allow health care professionals who were previously unable to furnish and bill for Medicare telehealth services (including physical therapists, occupational therapists, speech-language pathologists and others) to receive payment for these services by expanding upon the definition of "practitioners."
- **Originating Site Fee** - Allow hospitals to bill for therapy, education and training services furnished remotely by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is at home.

- **Medicare Advantage** - Allow Medicare Advantage (MA) organizations to submit diagnoses, including audio-only telephone visits, for risk adjustment from telehealth encounters.
- **Established Patient Requirement** - Remove any requirement that the patient be an "established patient" and allow providers to establish care using telehealth for new patients by removing this language in the code descriptors.
- **Enrollment** - Exempt telehealth providers from enrolling their homes as a practice location when services are provided from the provider's home or have a modified enrollment process in place for the same.
- **Direct Supervision** - Allow providers to provide direct supervision using telehealth, as this helps to expand the reach of the health care workforce.

While there are still many barriers that limit the widespread use of telehealth, such as state licensing laws, the permanent adoption of the COVID-19 waivers would accelerate the innovations already taking place through telehealth. Even after the PHE ends, the threat of COVID-19 and other viral infections will remain in place, making telehealth services still necessary to protect the health of vulnerable populations. Reinstituting the telehealth restrictions that existed prior to the pandemic would be a missed opportunity to expand access to care, ensure the continuity of services currently provided through telehealth and build the needed infrastructure to prepare for future pandemics.

Temporary Extension of Category 3 Telehealth Services

CMS proposes to extend the category 3 services added to the Medicare telehealth list until the end of CY 2023. This category includes services added during the PHE for which there is likely to be a clinical benefit when furnished by telehealth.

AHPA supports the coverage extension of the Category 3 services and urges the agency to extend coverage for at least another year after the end of the PHE. We believe this would help assist in comparing the value of a service provided during and after a PHE, allowing the agency to gather more meaningful data. We are also concerned that terminating coverage of all Category 3 services at the end of the PHE would potentially result in the interruption of services for Medicare beneficiaries. Additionally, we encourage the agency to retain this third category as it provides a mechanism for CMS to test the value of emerging technology and other telehealth services in the future before making permanent policy changes.

Coverage of Audio-only Evaluation and Management Services

In response to the pandemic, CMS established temporary coverage for audio-only telephone Evaluation and Management (E/M) services based on the CPT codes for telephone services. CMS now proposes to permanently define interactive telecommunications system to include audio-only communications technology when used for telehealth services to diagnose, evaluate, or treat mental health disorders furnished to established patients when the originating site is the patient's home. CMS also proposes to limit payment for audio-only services to services furnished by practitioners who have the capacity to furnish two-way, audio-video telehealth services but are providing mental health services via audio-only because the beneficiary is unable to use, does not want to use, or does not have access to two-way, audio-video technology. CMS believes this proposal would limit audio-only to situations facilitating access to care.

AHPA supports the permanent adoption and coverage of audio-only services. These services help to equitably expand access to care by providing options to those who do not have access to audio-video telehealth services or do not know how to use the technology properly. According to the Pew Research Center, roughly a quarter of adults with household incomes below $30,000 a year (24 percent) say they do not own a smartphone. About four in ten adults with lower incomes do not have home broadband services (43 percent) or a desktop or laptop computer (41 percent).[1] Eliminating coverage for audio-only services at the end of the PHE could impact access to care and exacerbate existing health care inequities. A recent study over telehealth acceptability during the COVID-19 pandemic also found that individuals in behavioral health treatment programs found telehealth, including audio-only services, to be an acceptable and even preferred mode of service delivery. Moreover, 80 percent of participants indicated that they would be interested in continuing to receive services remotely after the PHE ends.[2]

AHPA urges the agency not to adopt any additional documentation requirements for the provision of audio-only services. We believe that a statement on the medical record specifying that the services meet the criteria specified by CMS (beneficiary is unable to use, does not want to use, or does not have access to two-way, audio-video technology) should suffice. Adopting additional documentation

[1] Pew Research Center. Digital divide persists even as Americans with Lower Incomes Make Gains in Tech Adoption; Published June 2021
[2] Psychiatric Services: Telehealth Feasibility for People Served in a Community Behavioral Health System; Published June 2021

requirements could lead to clinicians refusing to offer these services because of the increased administrative burden posed by CMS.

Face-to-Face Visits for Mental Health Services

The Consolidated Appropriations Act of 2021 removed Medicare's originating site requirements for mental health services provided via telehealth and allowed a patient's home to be considered an originating site. The Act also adopted certain guardrails, such as requiring a face-to-face visit to happen at least six months *prior* to the telehealth visit and at a time thereafter to be determined through rulemaking. In this rule, CMS proposes a face-to-face visit at least once within six months after the first telehealth service. CMS seeks comments on whether a different interval, shorter or longer, may be appropriate for the subsequent in-person service.

AHPA does *not* support the creating a specific timeframe for a follow-up, in-person visit as we believe that decision is better left to the physician and patient. Setting a timeframe for an in-person service does not consider the wide range of services that telehealth covers, each with a varying degree of need for in-person visits or none depending on the patient's diagnosis and care preferences. We view the six-month requirement as arbitrarily set and not conducive to widening the scope of access to care. Due to the shortage of behavioral health professionals, we believe that establishing a specific timeframe for an in-person visit may hamper the continuity of mental health services. A mandate requiring an in-person visit within a specific timeframe is not feasible when there are none or very few mental health professionals in a community. Moreover, individuals facing severe depression or mobility challenges may decide to discontinue receiving aid altogether as mental health services are often not deemed a priority for many individuals. This requirement could also create greater barriers for individuals living in rural communities and those who lack transportation or cannot afford childcare, leading to unintended inequitable outcomes.

Appropriate Use Criteria (AUC)

Congress created the Appropriate Use Criteria program to promote the appropriate use of advanced diagnostic imaging services provided to Medicare beneficiaries. In this rule, CMS is proposing to postpone the payment penalty phase of the program until January 1, 2023, or January 1st of the year after the end of the COVID-19 PHE.

AHPA commends CMS for its decision to delay the payment penalty phase of the AUC. We strongly support the new compliance date as it reflects the challenges that providers face in dealing with the Delta COVID-19 variant. We urge the agency to use this time to conduct additional outreach about the program and address any challenges.

AUC Program Claims Edits

CMS is seeking feedback on whether claims that do not pass the AUC claims' processing edits should be initially returned to the health care provider to be corrected and resubmitted, or should the claims be denied so they can be appealed.

AHPA believes it would be best for claims that do not pass the AUC claims processing edits to be returned so that providers have an opportunity to make corrections and resubmit.

Quality Payment Program (QPP)

Merit-based Incentive Payment System Value Pathways (MIPS MVPs)

In 2019, CMS finalized a policy that would result in the agency sunsetting the MIPS program and replacing it with MVPs. These pathways would contain quality, cost measures and improvement activities with a specific focus, such as a disease, a specialty or an episode of care. CMS invites comments on when it should mandate MVP participation for all MIPS participants, proposing to sunset the current MIPS approach after the CY 2027 performance period.

AHPA believes that the proposed timeline is appropriate and offers sufficient time for clinicians to learn more about the transition and adequately prepare for the changes. We recommend that CMS use this time to reassess the currently required measures under the four performance categories mandated by MACRA: quality, cost, improvement activities and promoting interoperability. We believe that before adding any new quality measures, CMS should remove measures that may no longer be as relevant for improving quality of care and reducing costs. Otherwise, the continued expansion of quality measures would make it difficult for clinicians, particularly those serving in small practices or rural areas, to participate in the MVPs. Streamlining the QPP would reduce the regulatory burden on reporting and facilitate broader clinician participation.

MIPS- Promoting Interoperability Category

In the CY 2021 PFS final rule, CMS finalized a policy to align the certified EHR technology required for use in the Promoting Interoperability Programs and the MIPS Promoting Interoperability performance category with the updates to health IT certification criteria.

AHPA recommends that CMS consider reevaluating the program to determine which measures may no longer produce meaningful data or improve health care quality. If CMS seeks to have the program utilized by more practitioners of varying sizes, it is critical to streamline its reporting requirements. For example, we recommend that CMS consider removing data collection over Electronic Health Records (EHR) adoption**.** Most providers have adopted the usage of EHRs, thus making this quality measure no longer relevant in assessing the quality of care. According to the Office of the National Coordinator for Health IT, more than 86 percent of physicians have adopted EHRs.[3] Because EHRs are so widely adopted, we support replacing this measure with one that measures the use of Health Information Exchanges (HIEs). We believe that collecting data on the use of HIEs would be more beneficial as the health care industry strives to connect doctors, nurses, pharmacists and other health care providers with patients and their unique needs.

Inclusion of Certified Nurse-Midwives and Clinical Social Workers

CMS proposes to include social workers and Certified Nurse-Midwives (CNMs) in the definition of a MIPS eligible clinician. CMS is proposing to apply the same reweighting policy adopted previously for Clinical Nurse Specialists and Certified Registered Nurse Anesthetists to clinical social workers, citing that there may not be sufficient Promoting Interoperability category measures that are applicable to clinical social workers. However, CMS is *not* proposing the same policy for CNMs and requests comment on whether sufficient measures are available for CNMs and what barriers exist that may warrant reweighting.

AHPA supports the inclusion of CNMs and clinical social workers within the definition of a MIPS eligible clinician. We believe this policy could help address health disparities and lead to improvements in care quality. Many studies indicate that the use of CNMs can reduce maternal and fetal deaths and significantly improve the health of newborns.[4] Midwife care has been shown to result in

[3] Office-based Physician Electronic Health Record Adoption
[4] Sarawathi Vedam et al. Mapping Integration of Midwives Across the United States: Impact on Access, Equity, and Outcomes. Published in 2018, and Georgetown University School of Nursing. How Does the Role of Nurse-Midwives Change from State to State? Published in 2019.

shorter hospital stays and fewer preterm births and medical interventions. We also recommend that CMS work in partnership with the National Quality Forum (NQF) to determine which metrics could best be used for these two clinicians.

Medicare Shared Savings Program (MSSP)

Primary Care Service List Updates Beginning with PY 2022

CMS proposes updates to the list of primary service codes to be used beginning with PY 2022 for beneficiary assignment to MSSP ACOs. New codes include Chronic Care Management (CCM), Principal Care Management, certain prolonged E/M services and Communication Technology-Based Services (CTBS) HCPCS code G2252.

AHPA supports the proposed additions to the assignment code list. CMS has made changes over the years to keep assignments closely aligned with primary care relationships and we are pleased to see this pattern continue. However, we encourage CMS to make these methodologies consistent across different CMMI programs. For example, the treatment of CCM is different across various programs such as Primary Care First, Direct Contracting and MSSP.

Reporting of Electronic Clinical Quality Measures (eCQMs)

CMS proposes to freeze the quality performance standard at the 30th percentile across all measures through 2023 as an added incentive to report eCQMs. Additionally, for ACOs to be compliant with eCQM reporting, the rule requires entities to achieve the 30th percentile on a single measure. **AHPA supports this proposal and agrees with CMS that this will create an incentive for early adoption.**

ACO Quality Performance and MIPS

CMS had established through previous rulemaking that beginning with PY 2022, the Web Interface would no longer be available and MSSP ACOs would be required to report using their choice of other data submission types (e.g., eCQMs). CMS proposes to allow ACOs to delay the transition to the new all-payer eCQMs under the APM Performance Pathway (APP) from 2022 to 2024.

AHPA appreciates that CMS responded to prior comments regarding the need for additional time to prepare for the eCQM/MIPS CQM reporting measures. **We support the delayed transition as it would provide**

crucial time to ensure that ACOs have the infrastructure to accurately assess their performance and undergo provider education and care redesign if needed. AHPA supports the move to electronic reporting and recognizes the benefits of reduced manual chart abstractions. However, there are barriers to using eCQMs that CMS should seek to address, including the lack of standardization across EHRs and the administrative burdens and costs associated with the new reporting requirements.

We believe that the expansion to all-payer data for ACOs is also inappropriate and recommend that for eCQM reporting, CMS limit the reporting to Medicare assigned beneficiaries. While expansion to the broader population could provide a snapshot of care within a community, it is likely not representative of the care provided by the ACO. It is important to note that the MSSP is a Medicare program, so participating ACOs naturally target their services and interventions for their assigned Medicare patient population. Clarification is also needed on how the eCQM measures will impact the quality performance scores, especially if including non-ACO patients.

Quality Measure Set

CMS proposes to replace the Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs (MCC for ACOs measure) with the Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS (MCC for MIPS measure) for performance year 2022.

AHPA supports this proposal as this could reduce confusion for MIPS eligible clinicians who might otherwise have been scored on both measures with differing results. This also supports the agency's effort to align quality measures between MIPS and APMs.

Health Equity

AHPA applauds CMS for prioritizing the advancement of equitable and optimal health for all Americans. We are committed to health equity as a right of all people, acknowledging that it is an emergent issue for Black, Hispanic/Latinx, Indigenous and Asian communities. We support public policy solutions that consider the diversity in race, ethnicity, class, income, disability status and gender of the broader community. Therefore, we support CMS' effort to address health equity within Medicare's quality programs and welcome the opportunity to comment on the issues below:

We recommend that CMS reject the use of any health equity focused predictive algorithm, as these have been found to inject additional racial bias into patients' health care experiences.[5] We believe that the existing limitations in using race-estimation algorithms (e.g., limitations in surname analysis) outweigh the potential benefit of their use. Instead, we recommend empowering providers with more robust demographic data, including endorsing the use of patient self-reported race and ethnicity data. While observer-reported race and ethnicity data are still routinely used in care delivery, self-reported data have a much higher rate of validity—particularly for Indigenous, Latinx, Asian and Pacific Islander populations.[6]

Future Potential Stratification of Quality Measure Results by Race and Ethnicity

CMS is considering stratifying hospital-level reporting using race and ethnicity data, including using a standardized set of social, psychological and behavioral data from hospitals and individual providers.

AHPA supports CMS' goal of measuring, collecting and analyzing quality measures and outcomes data by race and ethnicity, and believes that this information will assist our member health systems in population health and equity-specific initiatives. To narrow the scope of the data stratification, CMS could consider initially requiring such stratification for a limited number of quality measures that are known to have significant national disparities. CMS may work with the National Quality Forum and the Department of Health and Human Services' Office of Minority Health to determine which measures within Medicare's quality programs should receive focus and develop a timeframe for the stratification of such measures by race and ethnicity. This approach would allow health providers, particularly those with limited resources, sufficient time to make any needed adjustments to their Electronic Health Records (EHRs) and address potential challenges relating to data collection.

We also recommend that any standardized demographic dataset under consideration capture social risk factors that impact wholistic health, including education level,[7] language spoken at home[8] and the incarceration status of an immediate family member.[9] In creating standard definitions for these demographic fields, we urge CMS to engage with local community groups as well as national associations to align standard definitions with the actual designations that patients use in self-

[5] The Harvard T. H. Chan School of Public Health. (2019). Widely Used Health Care Algorithm Has Racial Bias.
[6] Jarrín, O., Nyandege, A., Grafova, I., Dong, X., Lin, H. (2020) Validity of Race and Ethnicity Codes in Medicare Administrative Data Compared with Gold-standard Self-reported Race Collected During Routine Home Health Care Visits.
[7] Raghupathi, V., Raghupathi, W. (2020). The Influence of Education on Health: An Empirical Assessment of OECD Countries.
[8] Brodie, K., Abel, G., Burt, J. (2016). Language Spoken at Home and the Association Between Ethnicity and Doctor—Patient Communication in Primary Care: Analysis of Survey Data for South Asian and White British Patients.
[9] Lee, R. Fang, X, Luo, F. (2013). The Impact of Parental Incarceration on the Physical and Mental Health of Young Adults.

identification. This standardization will be invaluable for future health equity research and will ensure that the data captured can be comparable among providers.

In addition to adopting standard definitions, it will also be important for CMS to provide guidance on how to best collect the required data. To ensure data validity, we recommend requiring providers to use evidenced-based screening tools when collecting social determinants of health data. CMS could provide a list of options for hospitals to choose from for data collection purposes. Without standardization in EHR data collection, inaccuracies can be introduced that impede rather than support more equitable care delivery. Additionally, we advise that CMS provide guidance on a recommended frequency for collecting any social determinants of health data to ensure that such data is reported adequately and in a standardized manner.

Finally, we recommend that CMS stratify payer claims datasets provided to hospitals by race and ethnicity. Without it, hospitals and individual providers must attempt to connect the payer data with their own internal EHR data to create a profile of their patient population, potentially compromising the accuracy of the data.

Indirect Compensation Arrangements

CMS proposes to revise the definition of the Indirect Compensation Arrangements (ICA) to add another element. If there is an unbroken chain of financial relationships and the entity has the requisite knowledge, any arrangement in which the referring physician receives aggregate compensation that varies with or takes into account the volume or value of referrals or other business generated by the referring physician will be considered an ICA if the payment is for anything other than services personally performed by the physician. To guide the application of the new ICA definition, CMS also proposes regulatory text clarifying when services will be considered personally performed:

> "Services that are personally performed by a physician do not include services that are performed by any person other than the physician including, but not limited to, the referring physician's employees, independent contractors, group practice members, or persons supervised by the physician."

AHPA believes that the language above could be read broadly to declare that a surgeon cannot receive full credit for a procedure unless the physician personally performs every step of a surgical procedure without delegating any aspect of the procedure, such as closing the surgical site to professionals acting directly under the physician's supervision. Such intra-procedure delegation is common and CMS should not narrow the personally performed definition in this fashion or provide

"clarification" that is susceptible to this type of construction. It would be a construction wholly detached from the pragmatic workflow of many physicians and would not achieve any policy objective underlying the Stark statute.

Conclusion

AHPA welcomes the opportunity to discuss further any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact me at Carlyle.Walton@AdventistHealthPolicy.org or Susana Molina, Director of Public Policy, at Susana.MolinaRamos@AdventHealth.com.

Sincerely,

Carlyle Walton, FACHE
President
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